



APPLICATION FOR SPEECH-LANGUAGE PATHOLOGY ASSISTANT

INSTRUCTIONS: ALL SECTIONS OF THIS APPLICATION MUST BE COMPLETED. ANY CORRECTIONS TO THIS FORM MUST BE STRICKEN AND INITIALED. **DO NOT USE WHITE OUT ON THIS APPLICATION.** MAIL COMPLETED APPLICATION, ALL SUPPORTING DOCUMENTS, AND \$50 (NON-REFUNDABLE) FEE TO THE SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY BOARD.

PLEASE PRINT (IN BLUE INK) OR TYPE.

1. FULL NAME:		LAST	FIRST	MIDDLE
2. OTHER NAMES YOU HAVE USED:				
3. *ADDRESS OF RECORD:		STREET	CITY	STATE ZIP CODE
4. RESIDENCE TELEPHONE:		BUSINESS TELEPHONE:		
()		()		
5. SOCIAL SECURITY NUMBER:		DATE OF BIRTH:		
6. BASIS FOR FILING:				
ASSOCIATE OF ARTS OR SCIENCES DEGREE		BACHELOR'S DEGREE		

7. LIST NAME AND LOCATION OF ALL SATISFACTORILY COMPLETED UNDERGRADUATE EDUCATION. YOU MUST HAVE OFFICIAL TRANSCRIPTS DIRECT TO THE BOARD FROM EACH INSTITUTION AND, IF NOT POSTED ON OFFICIAL TRANSCRIPTS, A COPY OF THE ACADEMIC DEGREE/CERTIFICATE CONFERRED.

Institution	Location	Major Field of Study/Educational Program	Period of Attendance		Degree/Certificate Received & Date
			From (Mo/Yr)	To (Mo/Yr)	

8. IF THE APPLICANT DID NOT COMPLETE A SPEECH-LANGUAGE PATHOLOGY ASSISTANT PROGRAM APPROVED BY THE BOARD, THE APPLICANT MUST SUBMIT EVIDENCE OF COMPLETION OF THE REQUIRED FIELD WORK EXPERIENCE OR EMPLOYMENT WORK EXPERIENCE IN CONJUNCTION WITH ACADEMIC COURSE REQUIREMENTS, PURSUANT TO TITLE 16 OF THE CALIFORNIA CODE OF REGULATIONS, SECTION 1399.170.11. **A FIELDWORK EXPERIENCE OR EMPLOYMENT EXPERIENCE VERIFICATION FORM MUST BE COMPLETED AND SUBMITTED WITH THIS APPLICATION. PLEASE CHECK THE APPROPRIATE QUALIFYING EXPERIENCE:**

UNDERGRADUATE FIELDWORK EXPERIENCE _____ **EMPLOYMENT WORK EXPERIENCE (*)** _____

(*) Applicable work experience as defined in the above code section means the execution of duties or tasks of a speech-language pathology assistant as defined in Business and Professions Code Section 2538.1 (b)(4), for a minimum of nine months of full-time (30 hours a week or more) work experience. Work Experience completed while working in the capacity of a registered speech-language pathology aide under direct supervision does not qualify under this provision.

***YOUR ADDRESS OF RECORD IS PUBLIC INFORMATION AND WILL BE RELEASED UPON REQUEST.**

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9. HAVE YOU EVER BEEN LICENSED OR REGISTERED AS A SPEECH-LANGUAGE PATHOLOGY ASSISTANT BY ANY STATE, THE FEDERAL GOVERNMENT OR OTHER TERRITORY OF THE UNITED STATES? (IF YES, LIST ALL STATES OR COUNTRIES WHERE YOU WERE ISSUED A LICENSE OR REGISTRATION.)

YES _____ NO _____ STATE: _____

10. HAVE YOU BEEN THE SUBJECT OF ANY DISCIPLINARY ACTION REGARDING ANY HEALING ARTS LICENSE OR REGISTRATION WHICH YOU NOW HOLD OR HAVE PREVIOUSLY HELD?

YES _____ NO _____ (IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM)

11. HAVE YOU EVER BEEN DENIED A SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE OR REGISTRATION OR ANY OTHER HEALING ARTS LICENSE OR REGISTRATION, BY ANY STATE, THE FEDERAL GOVERNMENT OR OTHER TERRITORY OF THE UNITED STATES?

YES _____ NO _____ (IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM)

12. HAVE YOU EVER VOLUNTARILY SURRENDERED A LICENSE OR REGISTRATION TO PRACTICE IN THE HEALING ARTS IN ANY STATE, THE FEDERAL GOVERNMENT OR OTHER TERRITORY OF THE UNITED STATES?

YES _____ NO _____ (IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM)

13. HAVE YOU EVER BEEN CONVICTED OF, OR PLED NOLO CONTENDERE TO ANY OFFENSE, MISDEMEANOR OR FELONY OF ANY STATE, THE UNITED STATES, OR A FOREIGN COUNTRY? (EXCEPT VIOLATIONS OF TRAFFIC LAWS RESULTING IN FINES OF \$150 OR LESS)

YES _____ NO _____ (IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM)

You are required to list any conviction that has been set aside and/or dismissed under Penal Code Section 1203.4.

NOTE: The photograph AND the sworn statement below must be dated within sixty (60) days of the filing date of this application.

**ATTACH 2" x 2" OR 3" x 3" PASSPORT
QUALITY PHOTOGRAPH HERE**

STATEMENT OF APPLICANT

I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE HEREIN ARE TRUE IN EVERY RESPECT, AND THAT MISSTATEMENTS OR OMISSIONS OF MATERIAL FACTS MAY BE CAUSE FOR DENIAL OF THIS APPLICATION, OR FOR SUSPENSION OR REVOCATION OF MY LICENSE.

I FULLY UNDERSTAND THAT I MAY NOT PRACTICE AS A SPEECH-LANGUAGE PATHOLOGY ASSISTANT IN THE STATE OF CALIFORNIA WITHOUT WRITTEN NOTIFICATION FROM THE CALIFORNIA SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY BOARD THAT I MAY DO SO.

DATE: _____ SIGNATURE: _____
(MUST BE SIGNED IN **BLUE INK**)